Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M4-03-9228-01
Dr. Jack Cockburn 14232 Marsh Ln #184 Addison, TX 75001-3857	
Respondent's Name: American Protection Insurance Rep Box: 42	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary from the Table of Disputed Services states in part, "...Service was preauthorized. Denied as unnecessary w/peer..."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "...Payment is being processed with interest as soon as I have check #'s & amounts of payments. All parties will be notified..."

Principle Documentation: 1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11-05-02 through 11-18-02	O, V, F	97799-CP	1-4	$0.00
TOTAL DUE				$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. The Requestor billed 7 units per day for CPT code 97799-CP for DOS: 11-05-02, 11-06-02, 11-07-02, 11-08-02, 11-12-02, 11-13-02 and 11-18-02. The Requestor only submitted copies of the reconsideration EOB's received from the Respondent. The Respondent used denial codes, "0-Denial after reconsideration on further review, no payment is warranted", "V-Unnecessary treatment with peer review/treatment not recommended by UR (TX only) audit only" and "F-Fee Guideline MAR.)

2. Per Rule 134.202(e)(5)(E)(i-ii), CPM (Chronic Pain Management) shall be $125.00 per hour for a CARF accredited program. A CARF accredited program for CPM is indicated by using the modifier-CA. The requestor did not bill using the CA modifier; therefore, the monetary value of this program is $100.00 per hour.

3. Numerous attempts made to get in contact with the Requestor have been unsuccessful. The phone number listed on the DWC-60 is not a working number. According to Directory Assistance (411) they found no listing for the healthcare provider's name or the name of the facility where services were provided.

4. The Respondent was contacted to verify if payment was issued as stated in their response dated, 08-18-03. Spoke to a Broadspire customer service representative who advised that payment for all DOS were issued to the Requestor on August 20, 2003. The Respondent faxed a copy of the amended EOB's. The following is a list of check numbers and amounts for the DOS in dispute issued by the Respondent:

   - Check # 61309006317 for DOS 11-05-02 and 11-06-02 in the amount of $1400.00.
   - Check # 61309006320 for DOS 11-07-02 and 11-08-02 in the amount of $1400.00.
   - Check # 61309006319 for DOS 11-12-02 and 11-13-02 in the amount of $1400.00.
   - Check # 61309006318 for DOS 11-18-02 in the amount of $700.00.

Based on amended EOB's received from the Respondent dated, 08-19-03, services have been paid in full and in accordance with the 2002 MFG; therefore a dispute for services above no longer exists.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor **is not** entitled to additional reimbursement.

Decision by:

Patricia Rodriguez — Authorized Signature

Patricia Rodriguez — Typed Name

11/9/06 — Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.